

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037036</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Pilot House</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1111 Washington Ave.</u> <u>Cairo</u> <u>62914</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Alexander</u>		Officer or Administrator of Provider (Signed) <u>03/21/02</u> (Type or Print Name) <u>Richard Stroh</u> (Date)	
Telephone Number: <u>(618) 734-3706</u> Fax # <u>(618) 833-4993</u>		(Title) <u>Asstant Comptroller</u>	
IDPA ID Number: <u>37-1272696001</u>		(Signed) _____ (Date)	
Date of Initial License for Current Owners: <u>08/25/88</u>		Paid Preparer (Print Name and Title) _____	
Type of Ownership:		(Firm Name & Address) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Telephone) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Richard Stroh</u> Telephone Number: <u>(618) 833-5070 ext. 11</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Pilot House# 0037036 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds16Bed / 5840 Bed Days

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,791</u>			<u>5,791</u>	13
14	TOTALS	<u>5,791</u>			<u>5,791</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 99.16%

D. How many bed-hold days during this year were paid by Public Aid?

49 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/05/88

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

Pilot House

0037036

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	16,050	1,331	1,793	19,174		19,174		19,174		1
2	Food Purchase		38,975		38,975		38,975		38,975		2
3	Housekeeping	18,700	2,547		21,247		21,247	82	21,329		3
4	Laundry	19,915	1,353	14	21,282		21,282		21,282		4
5	Heat and Other Utilities			17,571	17,571		17,571	175	17,746		5
6	Maintenance		1,837	3,865	5,702		5,702	3,819	9,521		6
7	Other (specify):*										7
8	TOTAL General Services	54,665	46,043	23,243	123,951		123,951	4,076	128,027		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records		3,024	8,847	11,871		11,871	876	12,747		10
10a	Therapy			495	495		495		495		10a
11	Activities	75,580	637	357	76,574	(2,070)	74,504		74,504		11
12	Social Services	52,023	480	3,743	56,246		56,246		56,246		12
13	Nurse Aide Training		27	1,089	1,116	2,070	3,186		3,186		13
14	Program Transportation			2,407	2,407		2,407		2,407		14
15	Other (specify):* Day Training Exp.			135,695	135,695		135,695	(135,695)			15
16	TOTAL Health Care and Programs	127,603	4,168	156,233	288,004		288,004	(134,819)	153,185		16
	C. General Administration										
17	Administrative	27,000			27,000		27,000	5,265	32,265		17
18	Directors Fees										18
19	Professional Services			22,129	22,129		22,129	(21,311)	818		19
20	Dues, Fees, Subscriptions & Promotions			1,975	1,975		1,975	(195)	1,780		20
21	Clerical & General Office Expenses		3,023	4,250	7,273		7,273	7,663	14,936		21
22	Employee Benefits & Payroll Taxes			35,577	35,577		35,577	3,468	39,045		22
23	Inservice Training & Education										23
24	Travel and Seminar							106	106		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,473	4,473		4,473	170	4,643		26
27	Other (specify):* See Pg 26			6,186	6,186		6,186	(5,786)	400		27
28	TOTAL General Administration	27,000	3,023	74,590	104,613		104,613	(10,620)	93,993		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	209,268	53,234	254,066	516,568		516,568	(141,363)	375,205		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Pilot House

#0037036

Report Period Beginning:

01/01/01

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,593	7,593		7,593	(1,385)	6,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,148	1,148		1,148	(1,148)				32
33	Real Estate Taxes			5,798	5,798		5,798	111	5,909			33
34	Rent-Facility & Grounds			38,400	38,400		38,400	(31,125)	7,275			34
35	Rent-Equipment & Vehicles			94	94		94		94			35
36	Other (specify):* See Pg 26			12,547	12,547		12,547	(12,547)				36
37	TOTAL Ownership			65,580	65,580		65,580	(46,094)	19,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		918		918		918		918			41
42	Provider Participation Fee			29,622	29,622		29,622		29,622			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		918	29,622	30,540		30,540		30,540			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	209,268	54,152	349,268	612,688		612,688	(187,457)	425,231			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Pilot House

0037036

Report Period Beginning: 01/01/01

Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (135,695)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(274)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,340)	30		9
10	Interest and Other Investment Income	(1,148)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(425)	27		18
19	Entertainment				19
20	Contributions	(240)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,361)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,547)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 27	(373)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (158,403)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(29,427)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (29,427)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (187,830)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/01

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pilot House# 0037036

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(2,340)	955	0	0	0	0	0	0	0	0	0	(1,385)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,148)	0	0	0	0	0	0	0	0	0	0	(1,148)	32
33	Real Estate Taxes	0	111	0	0	0	0	0	0	0	0	0	111	33
34	Rent-Facility & Grounds	0	536	(31,661)	0	0	0	0	0	0	0	0	(31,125)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(12,547)	0	0	0	0	0	0	0	0	0	0	(12,547)	36
37	TOTAL Ownership	(16,035)	1,602	(31,661)	0	0	0	0	0	0	0	0	(46,094)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(158,030)	7,937	(37,364)	0	0	0	0	0	0	0	0	(187,457)	45

Facility Name & ID Number Pilot House

0037036

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James K. Keller	50	Mulberry Manor	Anna	kel-Tech Mgmt. Co.	Anna	Mgmt Services
Jo Ann Keller	50	Holly Hill	Anna	JR's Centre	Anna	Day Training
		Lincoln Square	Jonesboro	ILS 1-3	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	3	Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 82	\$	82 1
2	V	5	Utilities		kel-Tech Management Co.	25.00%	175		175 2
3	V	6	Repairs & Maintenance		kel-Tech Management Co.	25.00%	404		404 3
4	V	19	Legal & Accounting		kel-Tech Management Co.	25.00%	289		289 4
5	V	20	Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	45		45 5
6	V	21	General & Adm. Expenses		kel-Tech Management Co.	25.00%	1,322		1,322 6
7	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	3,742		3,742 7
8	V	24	Staff Training		kel-Tech Management Co.	25.00%	106		106 8
9	V	26	Insurance Building & Vehicle		kel-Tech Management Co.	25.00%	170		170 9
10	V	30	Depreciation		kel-Tech Management Co.	25.00%	955		955 10
11	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	111		111 11
12	V	34	Building Lease Pmts.		kel-Tech Management Co.	25.00%	536		536 12
13	V								13
14	Total			\$			\$ 7,937	\$ *	7,937 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Pilot House

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Report Period Beginning: 01/01/01

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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Wages	\$	kel-Tech Management Co.	25.00%	\$ 876	\$ 876	15
16	V	17 Administrative Wages		kel-Tech Management Co.	25.00%	5,265	5,265	16
17	V	21 Clerical Wages		kel-Tech Management Co.	25.00%	6,341	6,341	17
18	V	6 Maintenance Wages		kel-Tech Management Co.	25.00%	3,415	3,415	18
19	V	19 Professional Services	21,600	kel-Tech Management Co.	25.00%		(21,600)	19
20	V	34 Building Lease	38,400	J&J Partners			(38,400)	20
21	V	34 Depreciation		J&J Partners		6,739	6,739	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 60,000			\$ 22,636	\$ * (37,364)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Pilot House # 0037036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jo Ann Keller	Owner/Admin.	Administrator	50.00	75,600	8	20.00	Administrator	\$ 24,000	17-1	1
2	James K. Keller	Owner		50.00							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12	Schedule of Owner Compensation all facilities Pg. 24										12
13								TOTAL	\$ 24,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pilot House# 0037036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization kel-Tech Mgmt Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Houskeeping	Mgmt. Fee Contribution	290,400	10	\$ 1,100	\$ 21,600	\$ 82	1
2	5	Utilities	Mgmt. Fee Contribution	290,400	10	2,349	21,600	175	2
3	6	Pest Control	Mgmt. Fee Contribution	290,400	10	55	21,600	4	3
4	6	Maintenance Vehicle	Mgmt. Fee Contribution	290,400	10	196	21,600	15	4
5	6	Maintenance Supplies	Mgmt. Fee Contribution	290,400	10	9	21,600	1	5
6	6	Maintenance Grounds	Mgmt. Fee Contribution	290,400	10	362	21,600	27	6
7	6	Contract Services	Mgmt. Fee Contribution	290,400	10	(111)	21,600	(8)	7
8	6	Repairs Vehicle	Mgmt. Fee Contribution	290,400	10	87	21,600	6	8
9	6	Repairs Building	Mgmt. Fee Contribution	290,400	10	48	21,600	4	9
10	6	Repairs Equipment	Mgmt. Fee Contribution	290,400	10	1,588	21,600	118	10
11	6	Transportation	Mgmt. Fee Contribution	290,400	10	3,193	21,600	237	11
12	19	Legal & Accounting	Mgmt. Fee Contribution	290,400	10	3,880	21,600	289	12
13	20	Dues, Fees, Subscriptions	Mgmt. Fee Contribution	290,400	10	609	21,600	45	13
14	21	General & Admin. Supplies	Mgmt. Fee Contribution	290,400	10	6,968	21,600	518	14
15	21	Postage	Mgmt. Fee Contribution	290,400	10	2,766	21,600	206	15
16	21	Software	Mgmt. Fee Contribution	290,400	10	564	21,600	42	16
17	21	General & Admin. Misc.	Mgmt. Fee Contribution	290,400	10	670	21,600	50	17
18	21	Telephone	Mgmt. Fee Contribution	290,400	10	2,839	21,600	211	18
19	21	Cell Phone Expense	Mgmt. Fee Contribution	290,400	10	3,106	21,600	231	19
20	21	Printing	Mgmt. Fee Contribution	290,400	10	100	21,600	7	20
21	21	Copier Expense	Mgmt. Fee Contribution	290,400	10	790	21,600	59	21
22	22	Payroll Tax Expense	Mgmt. Fee Contribution	290,400	10	17,189	21,600	1,279	22
23	22	Ins. Employee Group	Mgmt. Fee Contribution	290,400	10	30,815	21,600	2,292	23
24	22	Insurance Workmen's Comp.	Mgmt. Fee Contribution	290,400	10	2,304	21,600	171	24
25	TOTALS					\$ 81,476	\$	\$ 6,061	25

Facility Name & ID Number Pilot House# 0037036 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization kel-Tech Mgmt Co.
 Street Address 158 E Vienna Street
 City / State / Zip Code Anna, IL 62926
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	24 Classroom Supplies	Mgmt. Fee Contribution	290,400	10	\$ 618	\$	21,600	\$ 46	1
2	24 Staff Training	Mgmt. Fee Contribution	290,400	10	365		21,600	27	2
3	24 Seminars	Mgmt. Fee Contribution	290,400	10	438		21,600	33	3
4	26 Insurance Vehicle	Mgmt. Fee Contribution	290,400	10	1,046		21,600	78	4
5	26 Insurance Bldg. & Liability	Mgmt. Fee Contribution	290,400	10	1,240		21,600	92	5
6	30 Depreciation	Mgmt. Fee Contribution	290,400	10	12,837		21,600	955	6
7	33 Real Estate Taxes	Mgmt. Fee Contribution	290,400	10	1,488		21,600	111	7
8	34 Building Lease	Mgmt. Fee Contribution	290,400	10	7,200		21,600	536	8
9	6 Maintenance Wages	Mgmt. Fee Contribution	290,400	10	45,911	45,911	21,600	3,415	9
10	10 Nursing Wages	Mgmt. Fee Contribution	290,400	10	11,776	11,776	21,600	876	10
11	17 Admin. Wages	Mgmt. Fee Contribution	290,400	10	70,789	70,789	21,600	5,265	11
12	21 Clerical Wages	Mgmt. Fee Contribution	290,400	10	85,251	85,251	21,600	6,341	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 238,959	\$ 213,727		\$ 17,775	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Ford Credit		X	Van Loan	\$827.61	1/23/01	\$ 27,655	\$ 19,700	12/23/03	4.9000	\$ 1,148	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$827.61		\$ 27,655	\$ 19,700			\$ 1,148	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 27,655	\$ 19,700			\$ 1,148	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pilot House COUNTY Alexander

FACILITY IDPH LICENSE NUMBER 0037036

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 ext 11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>01-01-01-032-001</u>	<u>Lots 1 thru 12, Lots 37 & 38 Blk 47 Ci</u>	\$ <u>5,897.66</u>	\$ <u>5,897.66</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>5,897.66</u></u>	\$ <u><u>5,897.66</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 4,300

B. General Construction Type:
 Exterior
 Vinyl/Brick
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Healthcare	10,000	1987	\$ 16,000	1
2					2
3	TOTALS	10,000		\$ 16,000	3

12/31/01

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,602	\$ 961		\$ 1,258	\$ 297	\$ 9,113	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 4,189	\$ 280	\$ 280	\$	15 Yrs	\$ 816	71
72	Current Year Purchases	821	821	59	(762)	7 Yrs	821	72
73	Fully Depreciated Assets	47,406		890	890	5-7 Yrs	47,406	73
74								74
75	TOTALS	\$ 52,416	\$ 1,101	\$ 1,229	\$ 128		\$ 49,043	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	Winstar, Ford, 1995	1995	\$ 20,720	\$	\$	\$	5	\$ 20,720	76
77	Healthcare	E350, Ford, 2001	2001	27,655	5,531	2,766	(2,765)	5	5,531	77
78										78
79										79
80	TOTALS			\$ 48,375	\$ 5,531	\$ 2,766	\$ (2,765)		\$ 26,251	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 126,393	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,593	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 5,253	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,340)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 84,407	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 94 Description: Water Cooler \$94

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>80</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		191		191
3	Classroom Wages (a)		505		505
4	Clinical Wages (b)		954		954
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		420		420
8	Nurse Aide Competency Tests				
9	TOTALS	\$	2,070	\$	2,070
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,070		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits		38	1,050		38	1,050	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	38	\$ 1,050	\$	38	\$ 1,050	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Pilot House

0037036

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 149,550	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	81,548		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	128,673		8
9	Other(specify): See Pg 26	308		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 360,079	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,602		15
16	Equipment, at Historical Cost	100,790		16
17	Accumulated Depreciation (book methods)	(84,406)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,986	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 386,065	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,436	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	6,203		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(693)		35
	Other Current Liabilities(specify):			
36	Garnishments Payable	841		36
37	Employee Life Ins.	65		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 19,852	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,700		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 39,552	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 346,513	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 386,065	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 301,198	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 301,198	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	45,315	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 45,315	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 346,513	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 519,013	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 519,013	3
	B. Ancillary Revenue		
4	Day Care	135,695	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 135,695	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	838	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 838	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,476	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,476	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Handling Fee Income</u>	62	28
28a	<u>Loss on Sale of Asset</u>	(81)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (19)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 658,003	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	123,951	31
32	Health Care	288,004	32
33	General Administration	104,613	33
	B. Capital Expense		
34	Ownership	65,580	34
	C. Ancillary Expense		
35	Special Cost Centers	918	35
36	Provider Participation Fee	29,622	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 612,688	40
41	Income before Income Taxes (line 30 minus line 40)**	45,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 45,315	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Pilot House# 0037036Report Period Beginning: 01/01/01Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,075	96	21,564	224.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,506	2,610	16,050	6.15	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,972	2,116	18,700	8.84	18
19	Laundry	2,129	2,359	19,915	8.44	19
20	Administrator	400	416	24,000	57.69	20
21	Assistant Administrator	120	120	3,000	25.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,040	2,080	30,459	14.64	29
30	Habilitation Aides (DD Homes)	10,270	10,422	75,580	7.25	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,512	20,219	\$ 209,268 *	\$ 10.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	34	\$ 1,312		35
36	Medical Director	12	3,600		36
37	Medical Records Consultant				37
38	Nurse Consultant	88	4,400		38
39	Pharmacist Consultant	12	480		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	495		43
44	Activity Consultant				44
45	Social Service Consultant	29	1,015		45
46	Other(specify)				46
47	Psychologist Consultant	28	1,271		47
48	Dental Consultant	12	1,200		48
49	TOTAL (lines 35 - 48)	224	\$ 13,773		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description		Amount	
Jo Ann Keller	Adm/Owner	50	\$ 24,000	Workers' Compensation Insurance	\$	4,061	IDPH License Fee	\$		
Susan Middleton	Administrator		3,000	Unemployment Compensation Insurance		1,369	Advertising: Employee Recruitment		26	
				FICA Taxes		15,191	Health Care Worker Background Check (Indicate # of checks performed <u>6</u>)		72	
				Employee Health Insurance		14,030	PAC Dues		77	
				Employee Meals		274				
				Illinois Municipal Retirement Fund (IMRF)*			Schedule of Exp. & Adj. Pg. 25		1,922	
				Misc. Emp Benefits		652	Less: PAC Dues		(77)	
				kel-Tech Mgmt Alloc. Exp.		3,742	Less: Contributions		(240)	
				Less: Emp. Meals		(274)				
							Less: Public Relations Expense	(
							Non-allowable advertising	(
							Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,000				TOTAL (agree to Sch. V, line 20, col. 8)	\$	1,780	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)						
	Description		Amount							
			\$							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount	
Barnett & Levine	CPA Services		\$ 425	None		\$	Out-of-State Travel	\$		
FMGR	Legal Services		104				None			
kel-Tech Mgmt. Co.	Accting Services		21,600							
							In-State Travel			
							Seminar Expense			
							kel-Tech Allocation		106	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL			(agree to Sch. V, line 24, col. 8)			
			\$ 22,129				TOTAL	\$	106	

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

<p>Facility Name & ID Number <u>Pilot House</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>IL. Hlthcare Assoc. \$915</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>7</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>249</u> Line <u>12</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>Pilot House 33787 1/1/91</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>29,622</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0037036</u> Report Period Beginning: <u>01/01/01</u> Ending: <u>12/31/01</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>N/A</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>274</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation</p> <p style="padding-left: 20px;">a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.</p> <p style="padding-left: 20px;">b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____</p> <p style="padding-left: 20px;">c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</u></p> <p style="padding-left: 20px;">d. Have vehicle usage logs been maintained? <u>Yes</u></p> <p style="padding-left: 20px;">e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u></p> <p style="padding-left: 20px;">f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u></p> <p style="padding-left: 20px;">g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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Related Parties Schedule VII
Owners Compensation
Jan 1, 2001 - Dec 31, 2001

	<i>Totals/Entity</i>	<i>Holly Hill</i>	<i>ILS 1-4</i>	<i>JR's Centre</i>	<i>Mulberry Manor</i>	<i>Pilot House</i>	<i>Liberty House</i>	<i>Lincoln Square</i>	<i>kel-Tech Mgmt</i>	<i>Krypton</i>	<i>Glen Brook</i>
Don Pippins	\$ 98,464.24		\$ 12,000.00	\$ 26,000.00			\$ 6,000.00		\$ 12,264.24	\$42,200.00	
Denise Pippins	103,400.00	36,000.00	21,600.00	45,800.00							
Diana Alley	76,975.72	13,800.00	24,000.00	6,000.00	9,900.00			11,500.00	11,775.72		
Jo Ann Keller	99,600.00			2,000.00	73,600.00	24,000.00					
James K. Keller	15,800.00			2,000.00	13,800.00						
Jacob Alley	44,385.84								44,385.84		
James A. Keller	69,824.00								58,524.00		11,300.00
	<u>\$ 508,449.80</u>	<u>\$ 49,800.00</u>	<u>\$ 57,600.00</u>	<u>\$ 81,800.00</u>	<u>\$ 97,300.00</u>	<u>\$ 24,000.00</u>	<u>\$ 6,000.00</u>	<u>\$ 11,500.00</u>	<u>\$ 126,949.80</u>	<u>\$ 42,200.00</u>	<u>\$ 11,300.00</u>

Pilot House of Cairo, Inc.

Schedule XIX, F.

Dues, Fees Subscriptions and Promotions

F. Dues, Fees, Subscriptions and Promotions	
Description	Amount
Domestic Corp. Ann. Report	81
	77
Association Dues	915
Contributions	240
Subscriptions	384
kel-Tech Allocations	45
Surety Bond Fee	180
Total	1922

Pilot House of Cairo, Inc.
Schedule XV, Line 9, Col. 1
Current Assets - Other

Ins. Receivable Employees	
AFLAC	\$ (2.00)
Life	(35.00)
Hlth Ins	254.00
Employee Advances Receivable	<u>91.00</u>
	<u>\$ 308.00</u>

Pilot House of Cairo, Inc.

Schedule VI, Non-Allowable Expenses, Line 29

		Sch/Line
Clothing	\$ (47.00)	V, 12-3
PAC Dues	(77.00)	V, 20-3
Diapers	<u>(249.00)</u>	V, 12-2
Total	<u>\$ (373.00)</u>	